

EXHIBIT 11

**HAVENWYCK****HOSPITAL**

Auburn Hills, Michigan 48326

ELZEIN, AHMED

M# 000097619 11/13/1992

1054315-0014 11/12/2020

BCBS ASCENSION SMART HEA

D. YOON MD M IPL

NURSES SECTIONS: YELLOW Pages 1-17

SOCIAL WORKERS SECTIONS: BLUE Pages 18-25

RECREATIONAL THERAPY: GREEN Page 26

INTEGRATED ASSESSME...**IDENTIFYING INFORMATION/NURSING**

Patient Name: <u>Ahmed Elzein</u>		Date: <u>11-12-2020</u>	Time: <u>0400</u>
Gender: <input checked="" type="checkbox"/> M <input type="checkbox"/> F <input type="checkbox"/> TG:		Preferred Pronoun & Name:	
DOB: <u>11.13.92</u>	Age: <u>27</u>	Eye Color: <u>Brown</u>	Hair Color: <u>Black</u>
Address: <u>700 Cedar Rainbow</u>	City: <u>Grand Blaine</u>	State: <u>MT</u>	Zip: <u>48439</u>
Parent/Legal Guardian/DPOA Name:		Relationship to Patient:	Phone #:
Next Contact for parent/guardian for medication consents:			
Marital Status: (check one) <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partner <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Race: <u>Middle Eastern/Asian</u>	
What form of transportation did the patient utilize to arrive at the facility?	<input type="checkbox"/> Family or friend <input type="checkbox"/> Personal vehicle	<input type="checkbox"/> Facility Transport <input type="checkbox"/> Non-emergent transport	<input type="checkbox"/> Law Enforcement <input type="checkbox"/> Ambulance <input type="checkbox"/> Medicaid Transport <input type="checkbox"/> Other:
Patient accompanied by: <u>EMS</u>		Is patient DHS Ward of Court: _____ Temp/Permanent?	
Transferred from and/or Referring Professional (check one): <input checked="" type="checkbox"/> Emergency Department: <u>Ascension Genesys</u> <input type="checkbox"/> Scheduled assessment <input type="checkbox"/> Walk-In <input type="checkbox"/> Other:		<input type="checkbox"/> Voluntary <input type="checkbox"/> Involuntary <input checked="" type="checkbox"/> Petition & Clinical Certificate Reviewed	
Date of last Physical: <u>REF</u>		Date of Last Tetanus: <u>REF</u>	

VITALS

Height:	Weight (actual):	Weight (stated):	BMI:
Temperature:	Respirations:	Pulse:	BP:

ALLERGIES

<input type="checkbox"/> NKA <input type="checkbox"/> Iodine <input type="checkbox"/> Tape <input type="checkbox"/> Peanuts <input type="checkbox"/> Latex <input type="checkbox"/> Shellfish Type of Reaction: _____	
Medication: _____	Type of Reaction: _____
Medication: _____	Type of Reaction: _____
Other: _____	Type of Reaction: _____

PRESENTING PROBLEM

SOURCE OF INFORMATION: <input type="checkbox"/> Patient <input type="checkbox"/> Legal Guardian/DPOA <input checked="" type="checkbox"/> Records <input type="checkbox"/> Collateral Information provided by:	
CHIEF COMPLAINT (in patient's own words): <u>pt Ref to answer, stating "I do not know why I'm here."</u>	



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INTEGRATED ASSESSME.

PROBLEM REQUIRING TREATMENT

Must be completed within 72 hours (Acute Units & PHP) Must be completed prior to Tx Plan

SOURCE OF INFORMATION:

☒ Patient ☐ Parent/Legal Guardian/POA ☒ Records ☐ Collateral Information provided by:

Reason for treatment/ Chief complaint / Perception of the situation in the patient's own words:

Per patient: "I don't know I guess I was stressed out."

Current symptoms: cloudiness, poor eye contact, vague responses, poor insight, paranoia, delusions.

What are your goals for treatment?

"I don't know"


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INTEGRATED ASSESSMENT**SAFETY/RISK/CONCERNS**
 ATTENTION TO ALL SAFETY/RISK/CONCERNS IDENTIFIED BY THERAPIST, INCLUDE ALL SAFETY/RISK/CONCERNS IDENTIFIED BY VISUAL CUE SHEET, A&R,
 NURSING & PSY. EVAL. EACH ITEM CHECKED MUST BE LISTED ON PRIORITY PROBLEM LIST IN TREATMENT PLAN SECTION.

- ☐ Suicide Risk / Danger to Self
☐ Self-Injury Risk
☐ Homicidal
☐ Assault Risk/ Danger to others

- ☐ Sexual Acting-Out (SAO) Risk-AGGRESSOR
☐ VICTIM-Trauma/Abuse
☐ Elopement Risk
☒ Psychosis AH VH TH / Command

- ☐ Substance Use/Abuse/Dependence
☐ Mania / Anxiety / Panic attacks
☐ Other

CLINICAL FORMULATION AND SUMMARY

Per Clinical Certificate: This patient is a resident physician in the program director and a fellow resident express concern for his safety. They cite delusional behavior including accusing a work mate of placing a bomb in a locker and accusing a fellow of placing a "toxic, dangerous item" in his pocket.

He is a 28 yo male who presented calm yet guarded in his responses. He has poor insight into the reason for his hospitalization. He had poor eye contact and was flat affect. He denied prior tx. He denied any family history of mental illness. He did agree to take medications prescribed by doctor. It was prescribed Risperdal 2mg.

What are the necessary steps for discharge to occur? Describe interventions needed to address discharge barriers:

mood stabilization
 medication compliance
 verbal & consistent ST/HF
 attend group therapy
 commit to aftercare



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INTEGRATED ASSESSMENT

Identify the high risk psychosocial issues that requiring early treatment planning and intervention (i.e.; unattended children, adult caregiver for another, etc.)

None


Community resources and supports for utilization in discharge planning ? (i.e.; aftercare treatment resources, housing, financial aid)

Private Outpatient

Anticipated social work role in treatment and discharge planning?

provide support and guidance
provide psychoeducation
contact family
arrange after care

Title	Printed Name & Licensure	Signature	Date	Tit
Completed by: Social Worker	Nom A. Zein, MD, PhD	[Signature]	11-13-2016	2



HAVENWYCK HOSPITAL
1525 University Drive
Auburn Hills, MI 48326

Patient Name: ELZEIN, AHMED
Physician: DO SYNG YOON, MD
MRN: 097619
Admit Date: 11/12/2020
Unit: UNTD IPL

This patient care visit is being conducted via telemedicine.

Staff present with the patient during this telemedicine session: Eric Hill.




DATE AND TIME EVALUATED: 11/12/2020 at 10:50 a.m.

AGE: 27 years

This is a 27-year-old single African American male, who lives by himself.

JUSTIFICATION FOR HOSPITALIZATION: He was very suspicious, paranoid, delusional. He believes that people put harmful objects in his pocket.

CHIEF COMPLAINT: He states that he was not doing well and tired. He was lacking sleep.



HISTORY OF PRESENT ILLNESS: He has no previous psychiatric treatment. He stated that he was overworking. He was tired and lacking sleep at night. He stated that some of his friends became very concerned about him, but he did not go into details; however, it was reported that he was acting bizarre. He was suspicious, paranoid, delusional. He said people putting some harmful objects in his pocket such as putting poisons. His training director became very concerned.

PAST PSYCHIATRIC HISTORY: None.

CURRENT PSYCHIATRIC MEDICATIONS:

SUBSTANCE ABUSE/DEPENDENCE/USE HISTORY: None.

MEDICAL HISTORY: None.

ALLERGIES: None.

SOCIAL HISTORY: He is living by himself, working as internal medicine resident. His parents are still married and living together. He grew up with them. He denies being abused while growing up. He is currently internal medicine resident. He has no legal issues.

FAMILY HISTORY: Family history of mental illness: None.

**TELEMEDICINE PSYCHIATRIST EVALUATION
ADMISSION HISTORY AND EXAMINATION**

HAVENWYCK HOSPITAL

Patient Name: ELZEIN, AHMED

MRN: 097619

MENTAL STATUS EXAMINATION:

General Appearance: He is casually dressed.
Attitude/Behavior: He is guarded, evasive.
Motor Activity: Within normal limit.
Affect: Blunted.
Mood: Anxious.
Speech/Language: Speech: Normal.
Thought Processes: Logical.
Thought Content: He is paranoid and delusional.
Suicidal Risk: He is not expressing anything suicidal.
Homicidal Risk: He is not expressing anything homicidal.
Orientation: Fully oriented to time, place, and person.
Concentration/Attention Span: Concentration: Intact. Able to stay focused in conversation throughout the interview.
Recent Memory: Intact. He can give some of circumstances leading to admission.
Remote Memory: Intact. Able to give past life events.
Abstract Reasoning: Intact. Able to understand questions clearly, giving relevant replies.
Intelligence: Average. Good with vocabulary.
Judgment: Poor. Poor behavior prior to admission.
Insight: Poor. Poor understanding into the nature of his mental illness.

ADMITTING DIAGNOSES:

Psychiatric: Psychotic disorder, not otherwise specified (NOS).

Medical: None.

Psychosocial and Contextual Factors: To be further assessed.

PATIENT ASSETS: Average intelligence, employed, being in good physical health.

PATIENT LIMITATIONS: Poor insight.

PROBLEM LIST: Delusional and paranoid, poor insight.

INITIAL PLAN OF CARE: To provide with history and physical plus routine lab studies. He is started on Risperdal.

Program services: He is to receive medication management, group therapy, and recreational therapy on a daily basis.

Specific focus of treatment/services/care: To control symptoms of psychosis, to improve insight into the nature of his mental illness and his need for continued treatment.

Medication plan:

**TELEMEDICINE PSYCHIATRIST EVALUATION
ADMISSION HISTORY AND EXAMINATION**

HAVENWYCK HOSPITAL

Patient Name: ELZEIN, AHMED

MRN: 097619

Estimated length of stay: 1 week.

INITIAL DISCHARGE PLAN: To refer him to outpatient clinic upon discharge from the hospital.

PROGNOSIS: Fair.

I certify that:

- This patient requires hospitalization. This may include diagnostic studies.
- The hospitalization is age appropriate.
- There is a likelihood of a positive outcome.

On the basis of current available information, I anticipate that this patient will require medically necessary care beyond two (2) midnights.

Electronically Signed on 11/15/2020 07:45:23 PM (GMT 5:0)

Do Syng Yoon, MD

DSY/cp/mk

DD: 11/12/2020 01:49:08 PM

DT: 11/12/2020 06:09:27 PM

Job #: T1292417

**TELEMEDICINE PSYCHIATRIST EVALUATION
ADMISSION HISTORY AND EXAMINATION**

Job #T1292417

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HAVENWYCK HOSPITAL
1525 University Drive
Auburn Hills, MI 48326

Patient Name: ELZEIN, AHMED
Attending: DO SYNG YOON, MD
Medical Doctor: Namdeo Kale, MD
MRN: 097619
Admit Date: 11/12/2020
Interview Date: 11/12/2020
Date of Birth: 11/13/1992
Unit: UNTD

DATE AND TIME OF THE EXAMINATION: 11/12/2020, at 7:08 p.m.

REASON FOR CONSULTATION/CHIEF COMPLAINT: New patient H and P.

HISTORY OF PRESENT ILLNESS: This is a 28-year-old very pleasant male, who is currently admitted in the psychiatric facility in Havenwyck Hospital with unspecific psychosis. Patient denies any fever, chills, nausea, vomiting, diaphoresis. No cough. No expectoration. No hematemesis, melena, or hematochezia. Patient apparently was not sleeping well and also takes amphetamine for his ADHD, it is prescribed by the psychiatrist. He is not sleeping well due to patient is awake in the night and connectivity of online activity with friends. Patient denies any other issue, but he was tired and not sleeping well. Also, the patient noticed one time that during this phase, one of his colleagues, whom he did not know, had a locker next to him, came into the locker room area and put his head down put something in the locker, which caused him to become suspicious. Otherwise, no cough, no expectoration. No hematemesis, melena, or hematochezia. No COVID-19 exposure.

PREVIOUS PSYCHIATRIC ILLNESS: Significant for ADHD.

PRESENT MEDICAL ILLNESS: Flat feet, insomnia, and fatigue.

PREGNANCY HISTORY/STATUS: Male patient, not applicable.

PREVIOUS MEDICAL ILLNESS: Significant for flat feet, insomnia, fatigue.

PREVIOUS SURGERIES: Denies any.

KNOWN ALLERGIES: No known drug allergies.

SOCIAL HISTORY: Patient denies use of alcohol, tobacco use, illicit drugs.

FAMILY HISTORY: Noncontributory.

CURRENT MEDICATIONS: Patient takes amphetamine 30 mg b.i.d.

REVIEW OF SYSTEMS: A 14-point review of systems obtained. Pertinent positive, negative documented in chart.

HISTORY AND PHYSICAL

HAVENWYCK HOSPITAL

Patient Name: ELZEIN, AHMED

MRN: 097619

GENERAL APPEARANCE AND PHYSICAL EXAMINATION:

General Appearance: Patient is alert, oriented x3, not in acute distress. Patient was cooperative.

Vital Signs: Patient's vitals are stable. Blood pressure is stable in the chart.

HEENT: Normal.

Neck: Supple. JVD is not raised.

Lymph Nodes: Normal.

Chest: Bilateral air entry is equal.

Heart: S1, S2 is normal. There is a S4 present. There is a small systolic murmur, which is in the aortic area.

Abdomen: Soft, nontender. Bowel sounds plus.

Spine and Extremities: Show foot calluses and flat feet.

Skin: No rashes.

Neurologic: CNS: No lateralizing sign. Cranial nerve examination: Grossly intact, I through XII. Motor system examination: Power is 5/5 in all 4 extremities without any incoordination or atrophy. Gait is normal.

External Genitalia (or reason for deferral): Deferred because of no symptom.

Pelvic Exam (or reason for deferral): Not applicable in male patient.

Rectal Exam (or reason for deferral): Deferred because of no symptom.

ASSESSMENT:

1. Foot calluses.
2. Flat feet.
3. Insomnia.
4. Fatigue.
5. Unspecific psychosis.
6. Attention deficit hyperactivity disorder (ADHD).
7. EKG revealed left ventricular hypertrophy (LVH).

RECOMMENDATIONS/PLAN: We will continue current care. Discuss with patient about sleep hygiene and follow up with psychiatrist for ADHD and also he would benefit from a 2D echo. Patient understands the recommendation and he will follow.

Electronically Signed on 11/14/2020 09:34:42 AM (GMT 5:0)

Namdeo Kale, MD

NK/vr/rk/sc

DD: 11/13/2020 12:38:56 AM

DT: 11/13/2020 04:14:25 PM

Job #: T1293646

HISTORY AND PHYSICAL

Job #T1293646

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HAVENWYCK HOSPITAL

Patient Name: ELZEIN, AHMED

MRN: 097619

HISTORY AND PHYSICAL

Job #T1293646

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HAVENWYCK HOSPITAL
1525 University Drive
Auburn Hills, MI 48326

Patient Name: ELZEIN, AHMED
Physician: DO SYNG YOON, MD
MRN: 097619
Admit Date: 11/12/2020
Unit: UNTD

This patient care visit is being conducted via telemedicine.

Staff present with the patient during this telemedicine session: Lindsey, RN.

DATE AND TIME SEEN: 11/13/2020 at 8:15 in the morning.

RESPONSE TO TREATMENT/PROGRESS TOWARDS GOALS/SIGNIFICANT UPDATES: He seems to be guarded. He stated that he got stressed out and lacking sleep prior to admission. He partly admitted he got paranoid prior to admission, but he does not seem to have good insight into unusual behavior prior to admission. He gets irritated at times. He denies hearing voices.

MENTAL STATUS EXAMINATION: Casually dressed. Evasive. Not agitated. Appropriate affect. Stable mood. Normal speech. Logical thought process. Still paranoid. Insight: Poor. Judgment: Poor.

ASSESSMENT: He remains unchanged.

TREATMENT PLAN: To keep him in the hospital for the next 4 to 5 days and to continue the current treatment plan with medications he is taking.

"I certify that the inpatient psychiatric facility services furnished since the previous certification were, and continue to be, medically necessary for, either treatment which could reasonably be expected to improve the patient's condition or diagnostic study and that the hospital records indicate that the services furnished were either intensive treatment services, admission and related services necessary for diagnostic study, or equivalent services.

I certify that the patient continues to need, on a daily basis, active treatment furnished directly by or requiring the supervision of inpatient psychiatric facility personnel."

Electronically Signed on 11/15/2020 07:49:27 PM (GMT 5:0)

Do Syng Yoon, MD

DSY/yr/sc

DD: 11/13/2020 12:05:37 PM

DT: 11/13/2020 10:42:12 PM

Job #: T1294224

TELEMEDICINE PSYCHIATRIC PROGRESS NOTE

Job #T1294224

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HOSPITAL**

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ELZEIN, AHMED 2
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TRANSITION OF CARE: DISCHARGE PLAN – PART I (To be completed by Physician)

REASON FOR ADMISSION: *Paranoid & racing thoughts, delusions*
Procedures/Tests Performed During Hospitalization: ☐ Lab ☐ X-ray ☐ EKG ☐ Other

Summary of Results:
N/A

 Are there any lab or x-ray results pending at discharge? ☐ Yes ☒ No

If yes, Facility Contact/Phone # to obtain results of any pending tests:

MEDICAL FOLLOW-UP REQUIRED:
Follow up w/ primary care providers
PCP FOLLOW-UP, if applicable: ☐ Yes ☐ No

LAB FOLLOW-UP, if applicable: ☐ Clozaril/CBC last level: Next level due: ☐ 1 week ☐ 2 weeks

☐ Blood Level necessary: ☐ Depakote ☐ Lithium ☐ Other

DIET: ☒ Regular ☐ Special diet

Activity Restrictions: *N/A*
Tobacco Cessation Medication at Discharge:
☐ N/A (Pt is not a smoker or smokes less than 1/4 pk per day.)

☒ Patient declined smoking cessation medications at the time of discharge.

☐ OTC/prescription medications for tobacco cessation are recommended and listed on discharge medication document.

DISCHARGE MEDICATIONS: (See attached Discharge Medication Reconciliation Document.)
DISCHARGE DIAGNOSES and FUNCTIONING
Psychiatric Diagnosis:
Psychotic del. NOS
Psychiatric Functioning at time of Discharge:
stable
Medical Diagnosis:
none
Medical Functioning at time of Discharge:
n/a
Dr. Yoon

Physician Printed Name

D. Yoon MD

Signature

11/17/20

Date

12:15

Time